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ABSTRACT

This paper provides a personal account of the process of psychotherapy for Acquired Immune Deficiency Syndrome (AIDS) patients, as seen from both the client's and the psychotherapist's perspective, with a focus on countertransference issues found in the early phases of treatment. Based on case material, the discussion explores themes presented by 16 AIDS patients in the Lake County (Illinois) AIDS Support Group and a separate AIDS information and family support group. The discussion is organized around the three stages of the disease: Human Immunodeficiency Virus (HIV) positive diagnosis; the AIDS-related complex; and the terminal stage of AIDS. Each section provides a discussion of psychological tasks and countertransference issues associated with critical events of each stage: (1) the decision to be tested, psychological response to a positive diagnosis, and developing a medical response; (2) effects of AIDS on functioning and relationships and on lifestyle; and (3) serious medical complications, loss of independence, struggle for acceptance of self and others, unfinished business, and acceptance of death. The countertransference themes include collusion with the patient's denial, unconscious distancing by the therapist, confrontation with personal mortality, survivor guilt, management of a borderline AIDS patient, unconscious prejudice, response to the death of a child, and resistance to a change in the therapist's traditional role. (TE)

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PSYCHOTHERAPY WITH AIDS PATIENTS: COUNTERTRANSFERENCE ISSUES

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PSYCHOTHERAPY WITH AIDS PATIENTS: COUNTERTRANSFERENCE ISSUES

I. INTRODUCTION

Through my work with AIDS patients and their families, I have developed some understanding of the process of psychotherapy as seen from both the client's and therapist's perspective. The following discussion presents my personal account of this experience and will focus especially on some countertransference issues found in the early phases of treatment.

Because of the sinister nature of AIDS, particularly the devastating prognosis, most therapists are finding the treatment of AIDS patients very stressful. Although we may be conscious of an identification with the fear of AIDS and its accompanying psychological baggage, we know that these profound issues will touch off unconscious conflicts within us. Anticipating and understanding the nature of some of these countertransference reactions is critical for the therapist and can make the stress of treating AIDS patients more manageable and the sessions more productive.

I had no personal experience with the treatment of AIDS patients until 1987, when I met Greg, who was HIV+. He and I started the Lake County AIDS Support Group. In this discussion, using case material, I will explore some themes that were presented by the PWAs (Persons with Aids) in our support group. Their agenda . . . their psychological issues, health issues, financial issues, relationship issues, spiritual issues, their experiences of grief, pain, social isolation, ostracism and discrimination, as well as their courage, strength and feelings of deep concern and care for each other . . . will serve as background for this analysis of countertransference in working with AIDS patients.

II. THE LAKE COUNTY AIDS SUPPORT GROUP

Although there are many AIDS support services in Chicago, the long drive (Chicago, in Cook County, is about 60 miles away) makes it inconvenient for Lake County residents who wish to attend a regular support group. To fill the need for a local group, the Lake County AIDS Support Group was started in the fall of 1987, sponsored by the Lake County Health Department. The group is open to men and women who have been diagnosed HIV positive. Membership is kept confidential; there is no registration, nor any fees. The group meets weekly at a centrally located hospital.

At present, we have 16 members; ten men and six women. Attendance is sporadic, although there is a core group who come every week. The members are homosexual, heterosexual, white, black, hispanic. Group members range in age from early 20's to early 50's. Many have a history of substance abuse and/or promiscuity. Their education ranges from high school dropouts to a few with graduate training. Two older group members have grown children; one young woman recently lost her two-year old daughter to AIDS; two other mothers have HIV+ children.

They are at different stages of the disease, some newly diagnosed, others in the middle stage; one woman, Shirley, has been diagnosed as having AIDS. Unlike in-patient AIDS support groups, our group has had very few deaths. We have found that, as people get sicker and develop full blown AIDS, they need a more intense, different kind of support. One former member moved into a hospital, another into a residential facility located in Chicago. Another is being taken care of at home by his parents. As mentioned above, one of our members, Jane, who has been diagnosed HIV+, had a daughter who died of AIDS complications last year. Sally was a little over two when she died. Her death had a most profound effect on all group members, including myself. Some of the countertransference issues arising from Jane and Sally's trauma will be explored below.

The overall goal of the group is to provide psychological support as the PWAs confront the tasks forced on them by the disease and by society. The sessions have no formal, planned agenda. We discuss whatever issues are brought up by the participants and "check in" with everyone in the sense of an update on personal, physical, and financial problems. We hope to help people move away from an initial sense of despair and fear, to a more stable position focused on developing the optimum management of a terminal disease so that they can live as fully as possible.

FAMILY SUPPORT GROUP

A separate AIDS Information and Family Support Group was organized soon after our patient group was formed in response to the needs of parents, siblings, close friends and other relatives. Most often these people come in soon after they learn of the AIDS diagnosis, in a state of shock and grief. Frequently, they confess that they have no one to talk to about their feelings. Many feel the conflict between their own long-held prejudice about anyone different from themselves (especially homosexuals and people with "social" diseases like AIDS) and the fact that their own son or daughter or sibling is

carrying the virus. Some families have never known (or accepted) their son's homosexuality and so they are reacting to a double shock.

The family group meets once a month. Initially, we had one combined group of AIDS patients and their families. However, we found that both groups needed to be able to talk freely, without concern about the impact of their words on their family members. Separating the two groups was better for all participants. (On the other hand, we have found that PWAs want their spouses or lovers to come with them to the regular support group meeting.)

Family members want to be able to express their feelings . . . their fear, rage, guilt, confusion, grief . . . about the individual they love as well as about the disease they hate. They are looking for both medical and psychological information and support as they begin to formulate a response to the reality of a positive diagnosis.

III. CRITICAL EVENTS, PSYCHOLOGICAL TASKS AND SOME EXPECTED COUNTERTRANSFERENCE THEMES. (Please see chart.)

A series of critical events, psychological tasks, and expected countertransference themes has been identified for each stage of the HIV disease. What follows is a discussion of my experiences with a few of these predicted psychological tasks and some countertransference reactions associated with each phase.

STAGE I. THE INITIAL STAGE: DX:HIV+

Critical Events

- A. The decision to be tested
- B. The initial psychological response to a positive diagnosis
- C. Developing a medical response

PSYCHOLOGICAL TASKS ASSOCIATED WITH THESE EVENTS

A. The decision to be tested

Most of the AIDS patients I have met contacted me after they learned of their positive diagnosis. However, on a few occasions, I have worked individually with people who were trying to decide whether to be tested or not. The decision to

PSYCHOTHERAPY WITH AIDS PATIENTS

CRITICAL EVENTS, PSYCHOLOGICAL TASKS AND COUNTERTRANSFERENCE ISSUES

<u>STAGE OF THE DISEASE</u>	<u>CRITICAL EVENTS</u>	<u>PSYCHOLOGICAL TASKS</u>	<u>COUNTERTRANSFERENCE ISSUES</u>
I. DX: HIV+	A. THE DECISION TO BE TESTED	OVERCOMING FEAR AND DENIAL	COLLUSION WITH DENIAL
		UNWILLING TO IDENTIFY SELF AS "MARKED"	UNCONSCIOUS DISTANCING
		UNIQUE PROBLEMS FOR MINORITY GROUPS	
	B. PSYCHOLOGICAL RESPONSE TO A POSITIVE DX	SHOCK/FEAR/PANIC/DEPRESSION/SUICIDAL IDEATION	CONFRONTATION WITH PERSONAL MORTALITY
		SELF-BLAME/WITHDRAWAL	
		DENIAL	MANAGEMENT OF A BORDER-LINE PATIENT
		ANGER	
		PRE-OCCUPATION WITH DEATH	SURVIVOR GUILT
	C. DEVELOPING A MEDICAL RESPONSE	COPING WITH PHYSICAL SYMPTOMS	UNCONSCIOUS PREJUDICE
II. DX: ARC	A. EFFECTS ON FUNCTIONING	BECOMING ACTIVE IN OWN TREATMENT	
		SHIFT FROM FOCUS ON DEATH TO FOCUS ON LIVING WITH AIDS	THERAPIST RESISTANCE TO SHIFT IN FOCUS/PRE-OCCUPATION WITH DEATH
		SHIFT FROM INTERNAL TO EXTERNAL ORIENTATION	
	B. EFFECTS ON RELATIONSHIPS	RESPONDING TO SOCIO-ECONOMIC LOSSES	IDENTIFICATION WITH IMPACT OF LOSSES
		CHANGES IN RELATIONSHIPS TO CHILDREN, SPOUSE, LOVER, FAMILY	RESPONSE TO DEATH OF A CHILD AND TO PARENTAL GRIEF
		POSSIBLE LOSS OF PRIMARY RELATIONSHIP	
	C. EFFECTS ON LIFESTYLE	IMPACT OF FINANCIAL CHANGE	DILEMMA OF HIV+ PATIENT AND HIS PREGNANT WIFE
		RESPONDING TO "LEPER" ATTITUDE	
III. DX: AIDS	A. SERIOUS MEDICAL COMPLICATIONS	WEATHER ATTACKS ON SELF-CONCEPT	FEAR OF OWN PHYSICAL DETERIORATION
	B. LOSS OF INDEPENDENCE	NEED TO ACCEPT CARETAKERS	RESPONSE TO CHANGES IN TRADITIONAL ROLE
	C. STRUGGLE FOR ACCEPTANCE OF SELF AND OTHERS	LIFE REVIEW	
	D. UNFINISHED BUSINESS	NEED TO FORGIVE SELF AND OTHERS, NEED REPARATION, RAPPROACHMENT	IDENTIFICATION WITH NEED FOR RECONCILIATION
	E. ACCEPTANCE OF DEATH	NEED TO DEVELOP OWN VIEW OF DEATH	

be tested usually follows a combination of physical and psychological events, e.g., they have had persistent medical problems which have been unresponsive to the usual treatment; they may be hospitalized and referred for testing at that point; in many cases a lover or close companion has just been diagnosed positive; others (admittedly fewer) react to the public health messages about drug abuse and sexual practices.

In order to agree to be tested, the individual has to be able, psychologically, to identify him/herself as potentially ill, as being diagnosed positive, as having full blown AIDS, and as "marked" by the social stigma attached to AIDS. They have to overcome the initial fear and denial which they share with the rest of society and which seems to be a universal response to AIDS. They have to confront any residual conflict they may have about their life style, their sexual orientation, their identification as "different". Some have compared their struggle before testing with the homosexual process of "coming out". They need to recognize and accept their anticipatory response to the experience of stigma and shame, in order to allow themselves to identify with the outcast group.

Blacks and Hispanics in our group have said that their decision to be tested was so difficult because of the additional pressure they felt from their community, whose unspoken judgement was that the greatest affront to their culture was to deviate from gender dominated group norms, e.g., prohibiting homosexuality, equating male illness with weakness.

Countertransference Theme: Collusion with Denial. (Therapist reaction to discussion of decision to be tested.)

As therapists, we recognize the possibility that our own resistance and fear of AIDS might allow us to collude with the patient's denial and wish not to know about a positive HIV diagnosis. The following example may be anticipated by others who treat AIDS patients.

I saw a male patient in his early 30's who was in the midst of a very nasty divorce. He was a bright, verbal, pleasant, likeable person, who conducted himself appropriately at all times. He said that his wife had been alcoholic and promiscuous. He thought she also used drugs, since she spent a lot of time with a "drug crowd". He had two small boys, who were living with him and who would probably be awarded to him in the divorce settlement, since his wife did not want them. He talked about his relationship to his sons and about his determination to provide love and stability, as well as financial support.

Although he said he had not been unfaithful before his wife left, he recently spent one night with a prostitute and was worrying that he had contracted AIDS.

He was depressed and obsessed with worry, focusing on his fear of being tested. He couldn't eat or sleep normally, he couldn't concentrate at work, he was short tempered and angry at his boys, and irritated at his mother who was taking care of the boys when he was at work. He could think of nothing beyond the testing decision. Nothing else mattered.

It seems so logical to be tested. In Lake County, Illinois, there is an anonymous testing facility. However, for him, the testing itself signified a diagnosis of AIDS and a sentence of death. Not only his own, but his wife's. Though he had stated that his fears of AIDS began after he had been out with the prostitute, it was clear that he believed his wife was probably positive and, in his mind, that made him positive too.

He could see only that his boys would be left alone, abandoned by both parents. That stirred up his own unresolved early trauma vis a vis his parents, his accumulated disappointments, resentments, despair. He had been proud of his ability to put that behind him, to be free of his early depression. Suddenly, here it was again and he felt overwhelmed by the revival of these old feelings.

As clinicians, we know how to react when a current incident touches off an infantile, unresolved trauma. Usually, we can rely on our training, experience and intuition as we work with a patient dealing with this sort of crisis.

But what about this case? How tempting it is to focus on the underlying intrapsychic issues and ignore the compelling necessity to help this person get tested immediately. Since we now know that the sooner the diagnosis is made and the sooner medication is started, the better the prognosis is; we can't allow ourselves to collude for even a day with the patient's wish not to know. We cannot fall back on the concept of therapeutic neutrality which trained us to refrain from any conscious manipulation of the outcome of a patient's decision.

And so, for this patient, his ordinary, middle class, well educated persona, his thoughtful, sensitive concept of parental responsibility, his understandable rage at his destructive wife, his classical depressive position, served as a momentary shield behind which I wanted to hide, rather than help him face and begin to deal with the fear he had that he (and she) might be HIV+.

Fortunately, for him, he agreed to be tested and his test proved negative. He has trouble believing the results and while

waiting to be retested, decided to continue in individual treatment in order to try to work through some of the underlying issues which were so disturbing to him.

B. Formulating an Initial Psychological Response to a Positive Diagnosis

The number of psychological tasks associated with this critical event is overwhelming to most newly diagnosed individuals, especially if they are poorly informed. In a rush of shock, fear, panic, self-blame, denial, rage, depression, suicidal ideation, despair and withdrawal, the person appears to be drowning in negative affect and feels hopelessly out of control, perhaps suicidal. The flood of emotion interferes with the capacity to start developing a response.

Others, newly diagnosed, seem to retreat behind a wall of denial and claim to accept the diagnosis without any turmoil. For example, one newly diagnosed male told me that "that was that" and there was nothing he could do about it and so he might as well accept what had happened and not "get too upset". (We can easily see how the therapist might be tempted to deny his/her own panic reaction to issues of death and dying and to unconsciously join in the patient's denial and, in so doing, distance him/herself from the patient.)

Most people I have met, however, react very powerfully to their first realization that they carry the AIDS virus.

As the first round of shock is absorbed, I have noted that some individuals become pre-occupied with their loss of a future and with their imminent death. For example, Greg gave his own birthday party in the first year after his diagnosis because he was convinced he would never reach another birthday, even though he felt fine.

The newly diagnosed individual becomes hypersensitive to all his relationships. Tragically, for some patients who have had a history of misunderstanding and alienation from their families, they may find that with the AIDS threat, the family withdraws completely, abandoning the individual to deal with the disease without their help. Even when families are supportive (unless they have had experience with someone who has also been diagnosed HIV+), neither they nor the patient are prepared for society's response, i.e., the pervasive social stigma, creating for the individual and those who care about him a sense of being a leper. Patients and families often compare themselves to cancer victims, commenting bitterly that if they had cancer, society would treat them differently, compassionately. People would not shun them, but would probably offer support and understanding. So it's entirely understandable that very often

PWAs, as well as family members, are very concerned about who (family or others?) they can tell and how they can tell them.

If the individual is involved in an intimate relationship, the initial concerns are that either the lover will abandon the patient, or that since he/she is positive and can spread the disease, as a measure of love and concern the infected individual should insist on separation. In either case, though, the future is lonely and feels like abandonment.

Countertransference Theme: Unconscious Distancing by the Therapist. (Reaction to patient developing a psychological response.)

As mentioned above, I met my first AIDS patient in May, 1987, when a 38-year old, white male came into our clinic with complaints of depression. Greg had known his HIV+ diagnosis for six months. He had some physical effects of the virus, e.g., weight loss, exhaustion, lymph node swelling, but was still working full time and living independently. He was involved in an AIDS study at a major university hospital in Chicago, although he was not yet on AZT.

Following the initial assessment, I recommended a combination of individual psychotherapy and pharmacotherapy for treatment of his depression, and referral to a support group. As indicated, we found that there was no AIDS group within a two hour drive, so we decided to try to form a local group, which we subsequently did.

I believe the support group has been extremely valuable to all group members and has provided Greg and others with a safe place to deal with terrifying issues and to feel a bond with others. In addition, Greg continued in individual psychotherapy. Over the course of three years, I have come to know Greg well, to understand his lifelong depression, his conflicts and defenses, to admire his basic kindness and his thoughtfulness, to feel the pain of his gradual loss of job, income, friends, health, independence. To share his frustration with our needlessly complicated system of financial support. To help him deal with constant physical exhaustion, with one medical problem after another, with medications and tests and with the necessity for acceptance of any unknown prognosis. To help him confront the issues of death and dying. And to feel a personal loss when he decided to move out of this area in order to live near his parents in anticipation of the time when he would need their help. He continues to stay in touch with me and with others in the group.

In analyzing the overall treatment, I realize that, although it was clinically correct to help Greg join a support

group, part of my initial motivation and the energy I put into starting the group, may have stemmed from an unconscious effort on my part to put some distance between myself and the patient. When I met Greg, I still had to learn not to be afraid. My response probably reflected by fear of AIDS and all the unknown and ominous issues, more than it did my recognition that such a group would help him. I realize now that by colluding in the effort to develop a group, we avoided dealing with the psychological issues on his agenda. Thus, it could be said, that my first intervention was directed more by countertransference pressure than patient needs.

Countertransference Theme: Confrontation with Personal Mortality. (Reaction to patient developing a psychological response to HIV+.)

As Greg and the other newly diagnosed individuals revealed their pre-occupation with death, their certainty that their own death was imminent, and that they were doomed never to find any further pleasure or happiness, I found that, as always with a terminally ill patient, I had to see myself in their situation and I had to still remain separated enough to be helpful. I identified with their rage at having life cut off so young, so abruptly; with their grief at separation from those they love; I tried to understand their sense of futility and hopelessness. I found myself joining with them in their very funny gallows humor, poking fun at the very most frightening subjects on their agenda. I shared their concerns about doctors, and hospitals, and medicines, about wills, and dwindling funds, and funerals. When they talked about what they had left undone, I felt my own regret at my unfinished tasks; when they talked about missing a life with the people they loved, I felt the significance of my relationship to my family.

Yet, as much as I identify with the patients' struggles with death and dying and theoretically accept that my death is as inevitable as theirs', our underlying concepts of "time left" are critically different. Their focus is on "time lost". Although the research to date does not claim with certainty that HIV+ status always leads to AIDS, the patients feel that they have been given a clear message that their death is a certain, impending reality. It feels to them like it is happening now, happening today. In reacting to the emotions of people working on these feelings, I have recognized that, in addition to my authentic sharing of their anguish in dealing with their losses, on another level, there is always an additional internal voice reminding me that for me, this is not today, this is not happening now.

Once again, this process provides an intrapsychic distancing from the patient and seems to be a deliberate search

for a clear boundary between the self and other, between safety and danger. This process is clearly a necessity in treating this population. We need this separation. But because this disease feels so random, so apparently meaningless, so unknowable (at this point, anyway), because the victims of this disease are as varied and as ordinary as you and me, it is extremely difficult to maintain that sense that we (as therapists) are really very different, very widely separated from "them". The unconscious fear is that we are not separated, we are not different. In this case, the fear arises from our knowledge that our "time left" is also unknown and unpredictable. But as we learn to recognize and tolerate this fear, I think a sensitivity develops which enhances our capacity to tolerate the pain and anguish of the patient's process through this early confrontation with death and perhaps help him/her refocus on time left, instead of time lost.

Countertransference Theme: The Phenomenon of Survivor Guilt.
(Reaction to patient developing a psychological response.)

I recognized the phenomenon of survivor guilt as I got to know Mitch and Harry. They are both in their early 30's, are well educated, verbal, bright, middle class. They have been together for more than five years. Originally from the south, they had moved here about a year before we met because Harry had gotten a good job offer here. They were happy with their relationship, their jobs, their apartment, their lifestyle. In the last several months Mitch had lost more than 40 lbs., but otherwise felt good. After a long period of medical tests to rule out one cause after another, his physician recommended that he be tested for HIV. He was HIV+. He came into our group about two months after his positive diagnosis. After a short initial shock phase, he very quickly became an AIDS expert, knowledgeable about various treatment protocols in Chicago, about which hospital was doing what, and where to go to get help for the predictable problems.

After Mitch was tested and found positive, Harry went in to be tested himself. He was negative. He has continued to go in for a test every few months and is still negative. His reaction is understandably conflicted. He says that they both lived the same lifestyle, both had similar histories, and yet only Mitch was infected. It doesn't make any sense to him . . . he said it feels random and meaningless. Of course, he is happy not to be sick. Of course, he like the rest of us, dreads the AIDS diagnosis. But just as understandably, he cannot rejoice in his own good fortune, since he feels Mitch's illness as his own. He is living with AIDS everyday, through his love for Mitch. His level of anxiety is probably higher than that of anyone else in the group. I have noticed that he doesn't report to the group about his test results, but Mitch does. The only way Harry can

talk about his feelings of guilt is through teasing and jokes, which he does very well.

I began to recognize that, incredible as it feels to me, on an unconscious level, I almost wanted him to test positive, in order to relieve his anguish and re-establish the balance between lovers. As I focused on what meaning this wish might have, I realized, as the therapist, I too was experiencing some survivor guilt. The process of transferring my guilt to Harry and having him act out the resolution allowed me to maintain my ideal of compassion and still remain safe and separate. Knowing people in the close way that one does in therapy and trying to understand their hopes and dreams and fears and pain, brings you into sharper focus with your own hopes and dreams and fears and pain. And makes you ripe for feelings of guilt when you believe that you will survive and they will not.

Countertransference Theme: Management of the Borderline Aids Patient. (Reaction to patient developing a psychological response.)

This dilemma crystallized as we were working on the issue of anger and reminds us that, in addition to the HIV diagnosis, we are also dealing with the underlying personality structure. Terry, a newly diagnosed HIV+ patient, was focused on her anger at AIDS, at the world, at her family, at life. I soon realized that what I focused on, was my anger at the patient.

Terry is a 27-year old, white female, mother of a daughter, age one. She had a history of alcohol and drug abuse and prostitution. She also had a history of physical and sexual abuse, which began when she was a child and which continued as an adult. She's currently living with an abusing partner. Terry had dropped out of high school in her sophomore year. She had never had a steady, stable job.

Terry discovered she was HIV+ while she was hospitalized for pneumonia. Her daughter was also tested and, fortunately, found negative. Terry was referred to our support group.

Unlike the majority of group members, Terry continued her patterns of drug and alcohol abuse as soon as she was discharged from the hospital. Of course, other group members who have a lifetime of substance use or abuse, don't all quit instantly when they learn they are HIV+. However, most people recognize that the best way to deal with the virus is to stay as healthy as possible. On an intellectual level, they resolve to make some healthy changes in their life even though, psychologically and behaviorally, they can't always do it. In contrast, Terry was convinced she didn't have to, didn't want to change. She ignored the medical advice on how to take care of herself and

the Public Health warnings on how to prevent further spread of the disease.

She broke all the group rules, most importantly, the group ethic of trust. One group member suspected her of stealing some of his personal property. She came to several group meetings, obviously having had a lot to drink. She blamed everyone she had ever known for everything. She divided the world into black and white, i.e., people either are "for me" (meaning, they do what I want, which was her definition of love) or they are "against me", her definition of hate. She quickly found the group to be "against me".

My reaction to Terry was probably like that of most people she meets. I instinctively pulled back, felt critical, and resented her presence in the group. Recognizing the Borderline qualities in her personality, I told myself I needed to try to work with her as with any Borderline, that is with very modest goals and concrete, simple objectives.

Yet, I continued to feel angry at her for upsetting my therapeutic neutrality and for betraying the trust of one patient in particular, who had made an effort to reach out to her. Identifying with that patient, I felt betrayed myself.

Can you be an effective therapist for a patient you actively dislike? When the patient is HIV+, do we have a different responsibility?

I have faced the first question before in treatment and have done one of two things:

a) try to work my way through my negative feelings, essentially focusing on the countertransference implications, until I have some understanding of my response and I can relate to a more acceptable aspect of the patient's personality. I have found that when I set out to overcome my initial negative reaction or "try to win over" a resistant patient, there is an element of challenge and the goal . . . less hostility on both our parts . . . becomes very desirable and frequently works. However, when it does not work, I will,

b) arrange to transfer the patient to a more neutral therapist.

Theoretically, if neither a) nor b) was helpful, then treatment would be terminated.

However, with AIDS patients, the choices are not the same. For example, at the time (1988), in Lake County, there was only one AIDS Support Group and very few therapists who would treat AIDS patients. So I didn't have the transfer option.

Therefore, my feeling of responsibility and guilt increased, along with my anger.

Terry and the group combined forces to manage the outcome of this dilemma. As part of the group, naturally I share some of the responsibility. The group could have tolerated her self-destructive practices. They could have and did try to help her understand more about the consequences of her behavior. They could have and did empathize with her tragic history and current conflicts. But they could not tolerate her violation of trust. As with any member of any group, once trust was destroyed, there was no bond, no relationship, no intimacy. She felt that and stopped coming to group.

When I called her, she said she was too busy for group or individual sessions. She calls me from time to time, always in crisis, usually drunk. My referral to alcohol and substance abuse programs are not what she wants to hear. I continue to feel a sense of regret and of unfinished business, as I have with other Borderlines who precipitously drop out of treatment. As I indicated before, Terry serves as a clear reminder to us that we are dealing with an HIV+ diagnosis superimposed on an underlying personality orientation. It is somehow easy to lose track of this dimension when we are faced with a new HIV crisis.

STAGE I, Cont'd.

C. Developing a Medical Response to an HIV+ Diagnosis.

Psychological Tasks

Dealing with the impact on self-concept of early physical symptoms, e.g., weight loss, exhaustion, sweating, lymph node swelling, herpes, etc.

Need to find a physician, get into a research study

Need to become an expert on treatment of HIV+ and AIDS

Countertransference Theme: Unconscious Prejudice: Therapist's Defensiveness (Reaction to patient's search for medical help.)

Mack is a 24-year old, black, gay male, who had just been informed that his HIV test was positive. He was referred to our group by the testing facility. When I first spoke to him on the phone, I thought he had a speech impediment. Knowing that he was HIV+, I wondered if he was suffering from a degenerative neurological process associated with AIDS. (So far, he has not identified any neurological problems.) Mack has developed a

habit of saying only half words and slurring them together and using idiosyncratic jargon, so that unless you have the general idea to start with, you have trouble understanding his meaning. He speaks very rapidly and in a quiet voice. I hoped that it would be easier to understand his speech in person. That is not the case. Even though I know him at this point, he is still very hard to understand. Although he is naturally warm and friendly, his speech deficits clearly interfere with his ability to connect with other people, including myself.

Mack's major problem, he said, was that he couldn't find a doctor who would treat him. He had no insurance and said he was unable to identify a local physician who would accept an HIV+ public aid patient. (Since I have worked in a Community Mental Health Clinic for many years, I have come across this problem many times. There is no doubt, in my mind, that people on public aid are often denied equal access to medical treatment.)

However, in this case, the group discussed with him the availability of medical treatment (without cost) at several Chicago hospitals, giving him specific names and phone numbers. Mack would seem to respond very positively to this information, but the next session, he would tell the group that he had not been able to get anywhere in his search for medical help. I wondered why this was happening to him, was this discrimination against him because of his race, because of his obvious lack of sophistication? On the other hand, was this his resistance to the diagnosis or was there something else going on? Beyond the fact that he had very little formal education, he was not familiar with Chicago or with the hospitals which have AIDS clinics; therefore, calling a Chicago facility and thinking of going there for an appointment was foreign and difficult; when he called to set up an appointment, he found that his calls weren't returned (his message was probably not understood) and so he didn't seem able to make any connection with the people he had been referred to. He became very easily discouraged, quick to feel that he was never going to get any HIV treatment.

After many, many weeks, Mack finally got settled with an AIDS clinic in Chicago; he has started taking AZT and is being evaluated for participation in a research protocol. He has stopped losing weight and looks and feels better.

Since he had so much more trouble connecting than anyone else, I had to consider whether his apparent inability to find a treatment site reflected a subtle difference in the way the group related to him, in sharing information about treatment locations, which made it harder for him to identify a medical home. Or, was he doing something to keep help away? That is, I wondered, if his feeling that he could not find help was his problem or the group's (i.e., mine). I realize, that on a certain level, I may have discounted his dilemma because I discounted his words. His language was a barrier in more ways

than I understood at first. Because he was so hard to understand, the empathic connection was not made in the same way that it is with other patients. I may have felt inadequate since I could not understand him and blamed him for my response. The process of his not getting through to me was probably transformed into a feeling of rejection on my part, along with a subsequent withdrawal from contact. Recognizing this response (which might also occur in other therapeutic situations), made it easier for me to get beyond the speech problem and to respond more appropriately to the problems as presented.

II. MIDDLE STAGE: DX: ARC

CRITICAL EVENTS:

- A. Effects on Functioning
- B. Effects on Relationships
- C. Effects on Lifestyle

PSYCHOLOGICAL TASKS

A. Effects on Functioning

These comments refer to the psychological events and tasks which occur just prior and during the middle phase of the HIV disease. Although the physical problems are increasing, the individual has gotten through the acute shock of the beginning phase and has become more active in his/her own treatment. They are less frightened and less resistant to medical treatment. They are usually very well informed about research, medication, different treatments. The middle phase patient has accepted the diagnosis and has begun to shift from an initial preoccupation with death to a concentration on how to stay as healthy as possible, how to live with AIDS. Whereas, they may have felt some panic earlier at the emergence of one symptom or another, in the middle phase, they accept the reality that they will have reduced energy, reduced libido, increased medical problems.

Medically, most of these people are labeled as having ARC, AIDS Related Complex. They probably have had many rounds of illnesses of varying sorts which, in addition to the overall weakening caused by the virus, take an enormous toll, e.g., in terms of lowered recuperative powers, negative medication reactions, loss of appetite, loss of strength, sleep difficulties, digestive problems, severe headaches, pain and soreness in muscles and joints, possible cognitive losses, etc.

Accompanying this, at least for the people in our group, one of the most significant and predictable psychosocial changes in the middle stage is the loss of their job, with its accompanying socio-economic toll. In the first phase of the disease, many HIV+ patients are able to continue to work for

many years. So, although their life changed because their expectations for a future are shattered by a HIV+ diagnosis, the outward manifestations of life, e.g., a job, a car, an independent place to live, are still intact. But when they are no longer able to work, mostly because they have become physically weakened and have too many medical problems--too many times they need to go to the doctor, too many times they have to call in sick, too many times they have to be hospitalized--then, at that point, everything ordinary and usual seems to change dramatically.

The psychological tasks which surround the shift from employed to unemployed status are complex and stressful for everyone and understandably more so for those whose retirement is forced on them because of physical illness. As we know, our culture defines individuals in terms of what they do, where they do it, and how valued they are in financial terms. The loss of a socially validated work identity, unfortunately, for some is equated with a loss of self.

Superimposed on this loss is the practical impact of income loss. The AIDS group members described their need to work out an alternative financial arrangement which they can depend on to cover their daily living costs, housing, medication, etc. Sometimes those who had insurance through their employment can continue some form of that insurance after they retire. However, most people in our support group need to work out some combination of public aid, social security and/or disability insurance as a basic maintenance formula. Some also need housing support as it becomes impossible for them to support an independent living arrangement. The process of arranging for public financial support is always complicated, always stressful, whether the individual has AIDS or not. Our group members stated that in order to make any headway getting through the red tape, they usually find they have to discuss their HIV status which, of course, they would prefer to keep confidential. Aside from the confidentiality issue, however, and unlike others who may be ambivalent as they try to put together a package of public support, the AIDS patients feel they are fighting for their lives and so are not at all conflicted about the urgency of their need for financial help.

What seems to me most distinctive about people who are in the middle phase of the HIV disease is their shift from an internal to an external focus. Whereas, earlier, right after they learned of their diagnosis, they were shocked into a period of narcissistic absorption with their disease, with their prognosis, with their losses, with their mortality. In the middle phase of the HIV disease, they move away from this introspective position to one in which they have an urge to help others, to be caring and loving to others, to become a public spokesperson on behalf of the AIDS battle. For example, many

community AIDS service and/or political action groups depend extensively on help from people who are positive themselves.

David, who has become the group caretaker, is an example of someone who has moved away from an internal preoccupation toward an externalized, nurturant position.

David is a 45-year old, gay, white male who had been a hairdresser all his life. When he first came into the group, he said that he had accepted the diagnosis, although he had not told anyone else, neither family nor friends. He had insurance and was financially stable and said he was living the best way he could and that he wasn't having any psychological problems. He said he was okay handling it on his own, but thought it might be interesting to talk to others with HIV+. But once he started talking, he couldn't stop. In a pressured, anxious fashion, he wanted to share endless details about himself, his physical problems, his work, his family, his social life, his physicians, etc. He could hardly tolerate the need for others to have equal time and, in fact, his interruptions became an irritant to other members of the group. He tried to use a torrent of words to deny, avoid, his feelings of fear and grief. He was totally preoccupied with his own ordeal. However, this manic, narcissistic style was a reflection of David's initial response to the HIV virus, more than a basic personality characteristic.

His shift in orientation became evident at the time that Jane's baby died. David allowed himself to empathize with her loss and grief and to stay internally quiet long enough to allow his responses to become known, to himself and others. He seemed to be able to give up his need to oververbalize, a technique he had used all his life in response to anxiety. He now was able to listen. And, when he did, his natural nurturant and caregiving nature emerged.

David had told the group that he had been taking care of an ailing parent for years and years and that he was her only caretaker. He did this as a natural and easy task, that any son would do if he could. It soon became obvious that caretaking was easy for David, because it was ego-syntonic. Once out of the initial panic response to his own illness, David was able to revert back to his natural pattern, seeing himself as able and willing to take care of others. In the group, David is the one who keeps tabs on how people are doing, he's the one who calls members who miss a session, he goes to visit others in the hospital. He literally nurtures the group, bringing something to eat and drink each week. For most members of the group, whose own needs are overwhelming, David's attention is a wonderful balm. However, I suspect that some others see him as overly involved, too anxious to please, too invasive. David's behavior stirs up for some a revival of the earliest infantile dependency position, with both the possibility of a return to the infantile bliss of total dependence on another, as well as

a possibility of rejection. Those whose primitive needs were never met in a satisfying way, react to him either in a repetition of their original experience or as a new opportunity for finally getting what they need.

But whatever meaning they evolve in response to David's behavior, he is generally accepted as he is. Whereas, earlier in their adult lives, they might have reacted to the surface meaning of David's overly involved gestures (and, in fact, those still in the initial shock stage do not accept David's gestures) at this point, many members have become more tolerant of individual differences and personality styles and have developed a thoughtful, gentle acceptance of each other. So David is seen as who he is, friendly, giving, anxious, insecure, wanting to please, caring. He still tends to oververbalize when he's worried, but his behavior is accepted.

B. Effects on Relationships

The middle phase of the HIV disease presents the individual with a time to clarify relationships. Major illness of any sort puts tremendous pressure on relationships, bringing out the best and the worst in all of us. For both heterosexual and homosexual couples in our group, if the relationship was basically weak, the chances are that they would have split before this stage. On the other hand, strong couples become more loving and supportive of each other and their relationship becomes more stable and meaningful. Together, the couple learns to deal with the physical and psychological meaning of living with AIDS. They support each other in the process of encountering the issues of death and dying. This process at one stage appears to create more anxiety in the uninfected partner (probably related to survivor guilt) than in the AIDS patient. In time, as the individual suffers from increasingly severe illnesses, the reality of the current and predictable deterioration shifts the focus away from the uninfected partner. This process of shifting back and forth between partners, between support for the other and absorption with the self, allows each to experience the process of loss and separation in smaller, more acceptable doses and probably serves to make the task of learning to accept death more tolerable.

If there is to be a rapprochement between estranged sons or daughters and parents, that, too, will have happened by this time (or be off the agenda). Given the HIV patient's thrust toward externalization, this is probably the most likely period for a reconciliation if there is to be one. There seems to be a willingness on the part of the infected individual to seek some kind of relationship, not to try to redo the past, but to establish a current connection. For some, the search for

rapproachment becomes an appropriate treatment task and can be worked on with the therapist's help.

The relationship between parent and child, when the parent is HIV+, also shifts during this phase. What seemed to happen for parents in our group, following the initial phase of the virus, was a period of recognition and intensification of the natural parental desire to protect and care for their child, whether the child was an infant or an adult. This desire was immediately infused with anxiety, with grief, with mourning, as they acknowledged that they, the parent, would not be alive to do the caretaking, to do the parenting, to teach, to protect, to guide and delight in the lifelong development of the child. As the individual orientation shifts in this phase from an internal to an external focus, the consequences of their death for their child become a source of intense anguish and turmoil. I have found that parents at this stage try to plan as much as they can for their child's future.

That is the case when the parent is HIV+ and the child is not. (Or not yet, according to the parental fear.)

However, when the HIV+ parent has a child who is also HIV+, the dilemma becomes incredibly complex and particularly poignant. Jane's story will serve as the background for our discussion on the countertransference response to death, although it will also serve as a description of this particular patient's reinterpretation of life.

Countertransference Theme: Response to Death and to Parental Grief. (Reaction to patient's response to death of her daughter.)

Jane is a 24-year old, single, white female, who discovered she was HIV+ immediately following the birth of her baby, Sally. At that time, Jane was living in a women's residential treatment facility where she was being treated for substance abuse. She describes her life before Sally was born as "pretty wild". She was a prostitute, using drugs and alcohol. She didn't care about much of anything, except continuing her life as it was. Jane says that the positive test result saved her life.

When we met, my first reaction to Jane was that she was highly intelligent, very verbal, beautiful and probably better informed about childhood AIDS than anyone I'd ever talked to. Her daughter Sally was about 18 months at that time and had been diagnosed at birth as having AIDS. Sally had spent much of her life in and out of Children's Hospital in Chicago. She was a bright, cheerful, strong-willed baby who was clearly a fighter. Though small in size, she appeared to be developing normally in spite of repeated bouts with serious illness, until at about 12

to 14 months, her neurological system began to be systematically destroyed by the AIDS virus. She seemed, tragically, to be regressing neurologically, from a more highly developed position, i.e., getting ready to walk, to a more infantile position, i.e., back to crawling, then even to losing the muscle coordination to do that or to sit unaided or finally even to hold her head without support.

Jane and her partner, Ted (who, though not the baby's biological father, provided loving fathering for Sally), were determined to do everything they could to take care of Sally at home. They turned their apartment into a hospital. When her condition required it, they immediately took her to Children's, got her stabilized, and then back home to her own environment. When she was not able to eat and required tube feedings, Jane and Ted learned how to do it. When Sally required a permanent cannulation to receive medication, again they learned what to do. Beyond the physical procedures, they learned how to handle the baby's psychological responses, along with their own. They managed to keep her at home.

Sally had a major crisis just before her second birthday. She was not expected to live. Sally, Jane and Ted were hanging on, maintaining their faith and good spirits, tolerating this incredibly traumatic ordeal. At Jane's invitation, the group visited them in the hospital. More than the other way around, Jane seemed able to comfort the other group members as they reacted to her tragedy. In another unbelievable show of strength, Sally began to improve and recovered enough to go home again. They celebrated her second birthday with joy and gratitude. And a certainty that she was dying.

Sally lived a few more months and then began to fail again. She died peacefully in her mother's arms at two years and three months of age.

Several group members attended her funeral because they wanted to support Jane and Ted and to honor the memory of this very brave child and because they identified with the AIDS diagnosis. As so often at a funeral, as observers, we reacted both to Sally's life and her death and to our feelings for Jane and Ted, to our own personal agenda, our own personal experience with the death of those we have loved.

I found that the countertransference dilemmas I encountered in trying to deal with Sally's death were extremely difficult and unlike my reactions to other patients I have known who are dying or who have died. With others, I have been able to understand enough of my responses to death and dying to put aside my personal needs and achieve a separation sufficient to enable me to try to be helpful to whatever that individual (or their family member) needs at the moment.

With Sally, from the moment we met, it was instantly, qualitatively different. Furthermore, I was very aware of my feelings. I was resistant to meeting her, knowing that I could not resist loving her, not resist the transference phenomena. I felt myself reacting to Sally as to my grandchildren, who are about her age. I responded to Sally's good and bad news as if she was my own grandchild. I found myself emotionally absorbed in Sally's illness and in Jane's response. When she was learning to walk and then when she was unable to walk and regressed back to an infantile stage of development, I found myself identifying with that stage in my grandchild's development. I felt a conflict between my vast relief that my family was not infected and my sense of the individual tragedy at hand for Sally, and for Jane and Ted. But all the above were conscious reactions and conscious interpretations.

The pressure of this response and my sense that I was not behaving therapeutically, forced me to try to explore the underlying countertransference phenomena. What was the origin, the meaning, of my instant identification of myself as grandmother, not psychologist, and of Sally, not as patient's child, but as my family?

As I have thought about it, I believe that, faced with the death of a patient, we, as therapists, tap into our deepest sense of self, our primitive relationships, our own developmental history, the threshold of our self-confidence, to look for guidance on how to manage our feelings of powerlessness. With this orientation, we become more basically human, more instinctive, more connected to those we love, more moved by a sense of spirituality, more sensitive to both the pain and the wonder of life.

As we try to make sense out of the loss of an adult, we are apt to remember the person in terms of their uniqueness, their personality, their relationships, their strengths and weaknesses. Frequently, what we recall is how they made us feel.

But, although we will attempt a similar review of our relationship, the death of a child is unlike other deaths we have experienced. The loss focuses on the issue of time. A life span so shortened feels like a monstrous mistake. It violates our expectations about life and mocks our smugness about the future. For this group of AIDS patients, this abrupt and unreasonable loss of life resonates with their own experience, their own fears. For some, the threat focuses on what they have yet to experience; but for most, the threat focuses on the relationships that they value, either primitive or current.

Sally's death, occurring in the context of the profoundly loving mother/daughter interaction that I had witnessed, brought me back to my similar relationships. Her death awakened in me an unconscious response to my personal mother/daughter history . . . to my relationship to my mother and to my daughters. Jane's loss revived my emotional connection to a sequence of real and anticipated losses. I reacted as daughter, as mother.

These responses as lifelong daughter and mother are primary, fundamental and instinctive and take precedence over my reactions as a psychologist. Thus, I am probably more confident of my intuitive familial reactions, than of my learned responses as a clinician dealing with the death of a baby.

On another level, my reaction, focusing on the mother/child relationship, indicates that I was attempting to avoid dealing with the fact that the others in our group were also infected and that they too would become increasingly ill and die. By keeping myself away from my identity as a psychologist, I was unconsciously indicating my resistance to dealing therapeutically with the process of death and dying which is on the agenda for the people in our group.

As I said, Jane's loss of her daughter is part of her ongoing AIDS struggle. Through some unknown and amazing cooperation between her maternal and physical selves, Jane's own HIV status remained apparently on hold until Sally died. This was Jane's biggest fear. That she would get too sick to be able to care for Sally. Since Sally died, Jane's T-cell count has dropped dramatically. She has started on AZT and has had a series of annoying, but not life threatening, medical problems.

In the past few months, Jane has become a spokeswoman for AIDS patients, especially for children with AIDS. She tells her own story to other women and men who may have sick children but who do not have her talent for knowing how to get the best possible help. She also goes out into the community to help inform people about this disease. Because she is so bright, and verbal and articulate, and because her story is so poignant, she is in demand as a speaker. Jane and Ted have applied to a foster placement agency in order to become foster parents for an AIDS baby. She plans to wait a year and then hopes to be able to offer her love and strength to another AIDS baby.

Jane says that her ability to do this is Sally's legacy. Though Sally is never out of her consciousness when she considered what her life had been, she is understandably proud and grateful for where she is today.

STAGE III. TERMINAL STAGE: DX: AIDS

Critical Events

- A. Serious medical complications--possible loss of some functioning
- B. Loss of independence
- C. Struggle for acceptance of self and others--need to confront lifelong anger, resentment, disappointments
- D. Focus on "unfinished business"
- E. Acceptance of death

PSYCHOLOGICAL TASKS

I have characterized the middle stage of the HIV disease as a rather stable period, in which the individual seems to be able to reach out to help others (in between their own bouts with various "opportunistic" diseases). As we know, this stage can continue for many years.

However, Stage III marks a dramatic shift from the externalized position characteristic of Phase II back to an internal orientation, a preoccupation with self. As the individual experiences round after round of increasingly serious medical problems, their physical complaints and medical treatment become the focus. They feel that their life is run by their failing body. The unpredictability of this disease, the fact that some people can live many years and maintain effective functioning, while others seem unable to withstand the multiple diseases, adds significant stress to the situation. The psychological task is to tolerate the overwhelming ambiguity. Group members talk about the frustration of trying to plan a life that has no predictable parameters.

Some patients, at this point, will agree to experimental treatments. One member of our group, Shirley, said that she had traveled out of the country in order to get some medication that was not available here. She said it was worth going and that she showed improvement as a result. She and others in the group often talk about their decision to "try anything" that seems to hold promise.

Another psychological task at this point is for the individual to try develop a way of weathering the continuous attacks on the self-concept imposed by physical deterioration and by accumulated losses in functioning. It seems to me, that in order to do this, the patients try to simplify their lives, try to prioritize, try to accept the limitations imposed by their loss of strength and autonomy. In the process, they talk about not being able to do the things they used to do with a mixture of grief and acceptance.

Because a loss of independent functioning is apt to be equated with a loss of self, this becomes one of the most difficult tasks facing the AIDS patient. Many people, grieving over their loss of functioning, feel conflicted when they recognize that they need another person's help in order to manage everyday living. Those in need of caretaking have to develop a capacity to accept the help offered without feeling resentful or guilty. This is a particularly difficult and sensitive issue for all of us who have learned to be independent, to avoid dependency and to distrust those who want to assume responsibility for our lives. And yet, of course, we all want to be able to depend on another, to trust that the other's behavior will be guided by our best interests. The way the individual reaches his/her own particular resolution of this task will no doubt be to follow a pattern characteristic of their lives.

The countertransference response to a loss of independent functioning, undoubtedly, will reflect the individual therapist's interpretation of self as performer vs. self as being intrinsically valuable. The fear of our own physical deterioration, the rage against our own body's decline, and the consequent feelings of helplessness and heightened dependency, will be triggered by the patient's struggle at this stage.

As the patient tries to formulate a revised view of themselves, which will accommodate a reduction in autonomy, in physical power, in goals, in dreams, they need to look back over their lives to see how they were at different stages of development. They need an opportunity to clarify who they were as a way of becoming comfortable with who they are at the moment. Many don't like what they remember about themselves at earlier stages. They struggle in their need to learn to accept, to forgive themselves.

The struggle for acceptance of self and others requires time and patience and a willingness to enter into a life review process. This requires patients to recognize and sort out all the residual anger and resentment and disappointments that have accumulated over a lifetime. As therapists, we can be extremely helpful at this point in the way that we provide acceptance as a model. Some people seem to be continually reviewing their lives, in a solitary search to understand and make sense out of what keeps happening. For this group, the task of self-acceptance is probably less difficult than for those who have never been able to look at the meaning of their behavior, at how they feel, how they affect others, how others affect them. They need to confront their feelings about themselves, their conflicts, successes and failures. Before they can forgive themselves for what they interpret as failures, they need to identify their early dreams, their hopes, their expectations. They can't look to others for reparation, for rapprochement, until they have settled the score with themselves.

In developing a capacity to accept themselves and the ways in which they have given meaning to their lives, they are in the process of preparing their personal view of death. In listening to our group talk about life and death, the sicker they are the calmer they seem to be. Those who are calm have apparently reached a point of satisfaction with their understanding of life and death.

Countertransference Issue: Resistance to Change in Traditional Therapist's Role. (Therapist reaction to patient's need to accept caretakers.)

I have recognized an internal conflict in my response to AIDS patients who need to have an increasing amount of caretaking. Those who have full blown AIDS need hands-on help with the everyday, practical tasks which, at this point in their lives, are perhaps more compelling for them than their need for reconciliation of lifelong conflicts. I am aware of how difficult it is for patients to accept the loss of independence and autonomous functioning. To the patient, this transition to a dependent position feels like regression and is interpreted as a loss of dignity. There is an understandable sense of outrage, resistance and grief. The loss of so-called "executive" functioning, again like other losses, feels like a loss of self. The question seems to be, if they are no longer a capable, independent, self-sufficient adult, then who are they? How can they maintain their balance in relationships, their place in the world, when they have lost their former sense of power and control, their mastery over their body and their life?

I believe that to understand the individual response to this transition, we need to focus on the unique meaning attributed by the patient to these losses and to the subsequent acceptance of help.

As psychologists, we are asked frequently to help people sort out, clarify, understand, regulate, re-examine the meaning--their interpretation--of transitional processes and events. We have an obvious role to play at this stage of the AIDS patient's life. But some changes are required in our traditional concept of psychotherapy when we are working with this population at this stage of their disease.

The treatment goals we usually develop in working with other terminally ill patients need to be expanded in order to include the unique dilemmas of the AIDS patient. For example, as I mentioned before, the usual social compassion for those dealing with death and dying is not available for this group. Our treatment will, undoubtedly, address this issue and the void created by society's (and for some, this includes their own family's) attitude. The process of treatment, the nature of the interaction, where and how we conduct the treatment, also has to

be re-examined. In many cases, we, as therapists, will go to the patient, not the other way around. We will be called on to provide practical nurturance in a way that may feel contrary to what many of us have learned and practiced.

In responding to some of these unique treatment requirements, I have become conscious of my resistance to any change in traditional clinical behaviors, since it feels like a threat to the separation of personal and professional boundaries and to my view of appropriate professional conduct.

For example, although I have often gone to visit a patient who is hospitalized, I interpret that visit as acceptable because I see the in-patient period as a particular phase of treatment. I see my visit as appropriate to maintaining a therapeutic relationship. I have also gone to see patients in their home, particularly in cases where they are unable to come in due to a physical disability (or unwilling to come in and certification is required). However, regardless of these exceptions, I know that I am basically uncomfortable with any shift away from the traditional clinical arrangement. So the AIDS patient in the hospital, the patient after surgery, the patient at home in a weakening condition, poses a dilemma for me. Intellectually, I want to provide whatever support I can. But intrapsychically, I want to stay as far away as possible.

I have recognized that I want to use my role as psychologist--my office, my schedule, my turf--to keep the boundaries between patient and self. As the patient's need for caretaking increases and they assume a more dependent position, I become more afraid of the increasing dependency relationship between myself and the patient. His/her regression feels too threatening to me, his/her needs too great. Though we know that most patients become dependent in treatment, the traditional goal is to understand and interpret these dependency needs, not to satisfy them. We are trained to try to avoid colluding with infantile, developmentally inappropriate needs. We have learned to watch ourselves for indications that the patient's behavior (increasing dependence) is not organized and energized to meet our intrapsychic needs. These practices feel safe for me. I can do this.

But, once again, the treatment demands with an AIDS patient contradict these traditional concepts. Their needs have caused all of us working in this area to re-examine our ordinary practices.

Both by training and by nature, I am somewhat formal and reserved in clinical practice. Thus, I am comfortable with the traditional neutrality of the therapist and uncomfortable when I am asked to move away from the safe comfort of my customary "role". In responding to patients who need caretaking, I feel a conflict between opposing purposes and, though I continue to

attempt to analyze the process, I have not satisfactorily resolved this issue.

CLOSING THOUGHTS

Everyday we read of new research on AIDS. Everyday we learn about new experimental medical treatments, new techniques, new "miracle" cures. And everyday the AIDS patients we know have to continue their struggle to maintain their physical strength and psychological balance.

Given the predictions that the numbers of people infected with the HIV virus will continue to grow rapidly in the foreseeable future, we as psychologists will need to be able to offer appropriate treatment in such a way as to benefit the patients and permit the therapist to manage the inevitable stress.

In this discussion, I have described my personal response to a series of countertransference dilemmas, which I have identified in the course of working with a group of AIDS patients. Although my experiences are limited to my work in Lake County, Illinois, I believe, in talking with others working with this population, that the general issues I have identified are common to many AIDS patients and their therapists.

I have described three distinct phases of the HIV disease and have identified a series of critical events, psychological tasks and countertransference issues which seem characteristic of each phase. Since most of my work is with an out-patient group who are still functioning well, I have spent most of this discussion on the first two phases of the disease.

The countertransference themes which have been analyzed include the following: the process of collusion with the patient's denial; unconscious distancing by the therapist; confrontation with personal mortality; survivor guilt; management of a Borderline AIDS patient; unconscious prejudice; response to the death of a child; and resistance to a change in the therapist's traditional role.

As with other patient groups, I believe that the more we can understand our conscious and unconscious responses to their unique issues, the more we examine the parallel processes set off in us by their experiences, the better able we will be to offer empathy, understanding and compassion in our treatment. Hopefully, in time and with additional experience, as clinicians we will also develop an increased capacity to manage the accompanying stress. In the meantime, as we learn more about the nature and treatment of AIDS, we must continue to offer what feels to us to be authentic, responsible and sensitive support.